MATERNAL AND CHILD HEALTH

FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report

The Maternal and Child Health Bureau (MCHB) provides leadership, partnership and resources to advance the health of all of our Nation's mothers, infants, children, and adolescents-including families with low income levels, those with diverse racial and ethnic heritage and those living in rural or isolated areas without access to care.

The Bureau draws upon nearly a century of commitment and experience. Early efforts are rooted in MCHB's predecessor, the Children's Bureau, established in 1912. Major program efforts of the Bureau include:

2.12 Maternal and Child Health Block Grant - Title V
2.12.a Healthy Start Initiative
2.12.b Traumatic Brain Injury Program
2.13 Universal Newborn Hearing Screening and Early Intervention
2.14 Emergency Medical Services for Children
2.15 Poison Control Centers
2.16 Abstinence Education Program

2.12 Program Title: Maternal and Child Health Block Grant - Title V

Performance Goals	Targets	Actual Performance	Refer -ence
I. ELIMINATE BARRIERS TO CARE **A. Increase Utilization for Underserved Populations** 1. Decrease the percent of children without health insurance.	FY 01: 10%	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 14% FY 96: FY 95: 14%	B195
2. Increase the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.	FY 01: 80%	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 70%	B195
3. Increase the number of children served by Title V.	FY 01: 24M	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 20.2 million	B195
4. Increase the percent of children with special health care needs (CSHCN) in the State with a medical/health home.	FY 01: 80%	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 69%	B195
5. Increase the percent of CSHCN in the State program with a source of insurance for primary and specialty care.	FY 01: 90%	FY 01: FY 00: FY 99: (Jan, 01) FY 98: (Apr, 00) FY 97: 83%	B195

6. Increase the percent of infants born to pregnant women receiving care beginning in the first trimester.	FY 01: 90 %	FY 01: FY 00: FY 99: (April, 01) FY 98: FY 97: 82.5 %	B195 HP-14
II. ELIMINATE HEALTH DISPARITIES **A. Reduce Incidence/Prevalence of Disease and Morbidity/Mortality** 1. Decrease the ratio of the black infant mortality rate to the white infant mortality rate.	FY 01: 2.1 to 1	FY 01: FY 00: FY 99: (Sept, 01) FY 98: FY 97: FY 96: 2.4 to 1 FY 95: 2.3 to 1	B195 HP-14
III. ASSURE QUALITY OF CARE **B. Assure Effectiveness of Care** 1. Decrease the infant mortality rate	FY 01: 6.9/1000 FY 00: 7.0/1000	FY 01: FY 00: FY 99: (April, 01) FY 98: (Apr, 00) FY 97: 7.1/1000 FY 96: 7.3/1000 FY 95: 7.6/1000	B195 HP-14
Total Funding: Maternal and Child Health Block Grant ($ in 000's)	FY 2001: $799,130 FY 2000: $799,130 FY 1999: $804,744 FY 1998: $776,605 (Funding totals include Healthy Start and Traumatic Brain Injury)	B x: page # budget HP: Healthy People goal	

2.12.1 Program Description, Context and Summary of Performance

The MCH Block Grant is the only Federal program that focuses solely on improving the health of mothers and children. It is specifically intended to (1) reduce infant mortality, (2) provide and ensure access to comprehensive prenatal and postnatal care to women, (3) increase the number of children

receiving health assessments and follow-up diagnostic and treatment services, (4) provide and ensure access to preventive and child care services, (5) provide and promote family-centered, community-based, coordinated care for children with special health care needs (CSHCN), and (6) identify pregnant women and infants who are eligible for Title XIX (Medicaid) and to assist them in applying for services, through outreach and enrollment.

The program has three main components: formula grants to States; and two Federally- administered discretionary project grant programs, special projects of regional and national significance (SPRANS); and community integrated service systems (CISS). These components are administered in a complementary fashion in support of providing quality health care to all mothers and children.

The MCH Block Grant is a public health program that complements the Medicaid and SCHIP health insurance programs which pay for a defined set of medically necessary services for low-income individuals meeting specific eligibility requirements. Historically, State Medicaid programs have relied on State MCH programs not only for maintaining the medical infrastructure, but also for assistance in enrolling eligible women and children, developing policies, procedures and practice standards that help providers and other agencies work more effectively with Medicaid, and organizing and providing services not available or accessible in the private sector.

In 1997 the Maternal and Child Health Bureau initiated a new Performance Partnership with the States. As part of this effort, MCHB and the States conducted a 16 month process in which representatives of the States, concerned interest groups, experts in public health, maternal and child health, public health data, and State data systems all participated. The process included two major meetings with representatives of all the State maternal and child health Directors, and extensive discussions with and input from the States. The purpose was to completely re-design the Block Grant Annual Report and Application Guidance, both in structure and process, to include a set of core performance measures that all States would report on, and a set of State-specific measures that individual States would negotiate with MCHB. The Annual Report and Application were re-structured around the core and State specific performance measures. The MCHB GPRA measures for the MCH State Block Grant program aggregate and use the State core measures to assess the overall performance of the whole State Block Grant program.

2.12.2 Goal-by-Goal Presentation of Performance

An initial set of MCHB GPRA measures has been identified to measure the national impact of the MCH State Block Grant program. These measures are based on the core set of measures that the States started reporting on, under the new Performance Partnership with the States, in FY 1998. The MCHB GPRA measures for the MCH State Block Grant program either aggregate and use the State-reported core measures data or, for vital statistics measures, the most recent CDC data to assess the overall performance of the State Block Grant program.

Goal I.A.1: Decrease the percent of children without health insurance.

Context:
While the association between insurance status and utilization of health care services is well documented in adults, less is known about the utilization of services by children. A 1996 study by Harvard, The Kaiser Foundation and National Opinion Research Center found the uninsured were four times more likely to have an episode of needing but not getting medical care. Other data indicate that children without health insurance have an average of one fewer visits per year, and receive less care than insured children with similar problems.

Performance:
Baseline: 14% of children without health insurance (1995).
Performance FY 97: 14%
Target FY 01: 10%
Indicator: The Percent of children without health insurance.

It is clear that HRSA is only one piece in helping to achieve this goal and that this is a nationwide problem that can only be solved with Federal, State and Community participation. MCHB will review the performance data reported by the States when it is edited, assembled and available this Spring. After sharing that data with HCFA and ASMB, HRSA will consider whether to revise the FY 01 Target.

Goal I.A.2: Increase the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.

Context:
Financial access to health care does not guarantee that all children will enroll and access care, but insured children are more likely to get care. Currently 4 million children are estimated to be eligible non-participants in Medicaid. By encouraging and helping all Medicaid-qualified children to enroll, State Title V programs help ensure access to health care services.

Performance:
Baseline FY 97: 70%
Performance FY 97: 70%
Target FY 01: 80%
Indicator: The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.

Goal I.A.3: Increase the number of children served by Title V.

Context:
The primary objective of Title V of the Social Security Act is "to improve the health of all mothers and children," especially under-served populations. Increasing the number of children served by Title V is central to accomplishing this purpose.

Performance:
Baseline: 20.2 million
Performance FY 97: 20.2 million
Target FY 01: 24 million
Indicator: The number of children served by Title V.

Goal I.A.4: Increase the percent of children with special health care needs (CSHCN) in the State with a medical/health home.

Context:
The MCHB accepts the American Academy of Pediatrics definition of and recommendation regarding the necessity of a medical/health home, and considers such a source of care to be essential for children with special health care needs.

Performance:
Baseline: 69% in FY 1997.
Performance FY 97: 69%
Target FY 01: 80%
Indicator: The percent of children with special health care needs (CSHCN) in the State with a medical/health home.

Goal I.A.5: Increase the percent of CSHCN in the State program with a source of insurance for primary and specialty care.

Context:
CSHCN are disproportionately low income, and because of this, they are at higher risk for being uninsured. Moreover, because their needs for health services extend beyond those required by healthy children, they are more likely to incur catastrophic expenses. Since children are more likely to obtain health care if they are insured, this measure is an important indicator of access to care.

Performance:
Baseline: 83% in FY 1997.
Performance FY 97: 83%
Target FY 01: 90%

Indicator: The percent of CSHCN in the State program with a source of insurance for primary and specialty care.

Goal I.A.6: Increase the percent of infants born to pregnant women receiving care \ beginning in the first trimester.

Context:
Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help assure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes. CDC data are used for this performance measure.

Performance:
Baseline: 81% began prenatal care in first trimester (1995).
Performance FY 97: 82.5%
Target FY 01: 90%
Indicator: The percent of infants born to pregnant women receiving care beginning in the first trimester.

Goal II.A.1: Decrease the ratio of the black infant mortality rate to the white infant mortality rate.

Context:
While the U.S. has made significant progress in reducing the overall infant mortality rate, there is still significant disparity in the rate for selected racial groups. The disparity for Black infant mortality is more than twice the White rate. CDC data are used for this performance measure.

Performance:
Baseline (1995): Black rate: 14.0 deaths per 1000 live births; White rate: 6.0 deaths per 1000.
Ratio: 2.3 to 1
Performance FY 96: 2.4 to 1
Performance FY 97:
Target FY 01: 2.1 to 1
Indicator: The ratio of the black infant mortality rate to the white infant mortality rate.

Goal III.B.1: Decrease the infant mortality rate

Context:
All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. CDC data are used for this performance measure.

Performance:
Baseline: 7.6 deaths per 1000 live births (1995).
Performance FY 97: 7.1/1000
Target FY 01: 6.9/1000
Indicator: The infant mortality rate.

Data Issues:
Data for the measures specified above are tabulated from the State Block Grant annual report and application, except for vital statistics data, which come from CDC.

The Maternal and Child Health Block Grant program, after extensive consultations with States and OMB, instituted performance-based reporting from all States, accompanied by electronic reporting, in FY 1998. The Maternal and Child Health Bureau had worked closely with the States to complete a re-engineering of the Maternal and Child Health (MCH)Block Grant Annual Report and Application Guidance into a single process. The revised approach includes not only a standardization of the application and reporting procedures required by the authorizing legislation (Title V of the Social Security Act), but also incorporates reporting on a set of quantitative performance measures.

The new guidance provides for an application/annual report process that is uniform for all States and jurisdictions, captures all the data required in the Title V legislation, and incorporates the principles of Performance Partnerships. Concurrent with the redesign of the Guidance, an electronic reporting system was developed that allows the States to submit their applications/annual reports electronically. It capture all of the qualitative programmatic information as well as the quantitative data necessary for performance measurement. In FY 1999, MCHB is implementing the Title V Information System, which provides users access to the consolidated data reported by all 50 States and 9 jurisdictions.

Data Limitations and Planned Improvements:
Significant improvements in the quality of data have already been accomplished by the standardization of definitions and formats imposed both in the new Performance Partnership and by the new electronic reporting format. One feature of the electronic reporting format requires that the raw data for rates and ratios be entered, and all calculations are done by the program. One difficulty facing MCHB is that different States have different data capabilities. This leads to the result that some kinds of data are collected by some States on a periodic basis - every two or three years, for example - while other kinds of data may vary in currency across States - so that not all States report data from the same year at the same time. MCHB will provide intensive additional assistance to the States in achieving standard data capabilities.

FY 2001 Performance Plan,Revised Final FY 2000 Plan and FY 1999 Performance Report

2.12.a Program Title: Healthy Start Initiative

Performance Goals	Targets	Actual Performance	Refer-ence
I. ELIMINATE BARRIERS TO CARE **A. Increase Utilization for Underserved Populations** 1. Reduce the percentage of enrolled women who receive late or no prenatal care. (New)	FY 01: 16.75%	FY 01: FY 00: FY 99: (Sept, 00) FY 98: 17.06%	B198
III. ASSURE QUALITY OF CARE **B. Assure Effectiveness of Care** 1. Decrease the percentage of low birth weight babies born to Healthy Start clients. (Revised) Original wording: Decrease by 1% the number of low and very low birth weight babies born to Healthy Start clients.	FY 01: 11.75%	FY 01: FY 00: FY 99: (Sept, 00) FY 98: 12.09% (Provisional)	B198
Total Funding: Healthy Start ($ in 000's)	[FY 2001: $90,000] [FY 2000: $90,000] [FY 1999: $104,967] [FY 1998: $95,526] (Funding for Healthy Start is included in the MCH Block Grant line.)	Bx: page # budget HP: Healthy People goal	

2.12.a.1 Program Description, Context and Summary of Performance

Context:

The FY 2001 Budget proposes that funds be made available first to continue making grants to Healthy Start grantees that were awarded funds on or before January 15, 2000, whose current grant award

continues in FY 2001. If the total amount of such grant awards is less than $90 million, at least 95 percent of the remaining funds will be available for States, under the cost sharing provisions of section 503 of the Social Security Act, according to the ratio that infant mortality in each State bears to the total of infant mortality in the U.S. Up to five percent of remaining funds are to be available for States for technical assistance. This would help to ensure a greater level of commitment toward collaboration and cooperation by State and local perinatal health systems in support of communities. The program will continue to target communities with racial, ethnic, and geographical disparity in perinatal health and other significant problems that contribute to high infant mortality. The grantees will be expected to implement strategies that complement their State maternal and child health systems and enhance collaboration with and among States in carrying out essential activities, such as Medicaid and the State Children's Health Insurance Program (SCHIP).

Healthy Start focuses on the need to strengthen and enhance community systems of perinatal health. It does this by helping communities to fully address the medical, behavioral and psychosocial needs of women and infants. The FY 2001 program will provide for a continuing opportunity to reduce factors contributing to infant mortality by adaptation of successful Healthy Start models of intervention in urban and rural communities with high rates of infant mortality, especially among racial/ethnic populations, and to share the lessons learned with States, communities, and academic and professional organizations.

Program-wide Performance:

In FY 1997, the Healthy Start program concluded its demonstration phase (Phase I). Twenty-two of the high risk communities, together with public/private partnerships implemented strategies to address the broad range of health, social, economic and educational unmet needs that result in high rates of infant mortality. A review of final reports from the projects which document their experience reveals their success in building community-based coalitions and achieving community- wide service system integration, improved care coordination, expanded level and range of services, and alleviation of other barriers to care. Cost savings have resulted from reducing low birth weight through promotion of healthy behaviors such as prenatal care visit compliance, smoking cessation and substance abuse treatment. In addition, the Healthy Start program is having broader impact on on-going public and private sector partnerships that have facilitated welfare to work and community job creation.

In the replication phase (Phase II), which began in FY 1998, actions were initiated to carry out three specific program goals: 1) expand the success of the Healthy Start program by replicating models of perinatal care which have shown evidence of strengthening the perinatal system: to date, 41 new communities are replicating infant mortality reduction strategies in their communities; 2) establish a peer mentoring program: to date, 20 projects from the demonstration phase are serving as peer mentors to new Healthy Start communities and other health care providers while continuing efforts to improve the perinatal health for women, infants and their families in their own communities; and 3) nationally disseminate knowledge and information on lessons learned: the Healthy Start National Resource Center project is fully operational and serves this purpose.

2.12.a.2 Goal-by-Goal Presentation of Performance

Goal I.A.1: Reduce the percentage of enrolled women who receive late or no prenatal care.

Context:
This is a new goal added to better reflect the expected outcomes for the Healthy Start population.
Indicator: The percentage of enrolled women who receive late or no prenatal care.

Goal III.B.1 Decrease the percentage of low birth weight babies born to Healthy Start clients. (This goal has been re-stated to make it more specific, and to adjust its format.**)**

Original wording: Decrease by 1% the number of low and very low birth weight babies born to Healthy Start clients.

Indicator: Number of deliveries/births weighing 1500-2499 grams.

Performance:
Provisional data reported by grantees indicates a baseline of 12.09% for the client populations served in CY 1998. Not all grantees have their own source for these data. Where it is necessary to use vital statistics data, reporting will take longer.

The following developmental performance goals have been set-aside in favor of goals more related to expected outcomes for the Healthy Start population:

> **Increase by 25% the utilization of comprehensive community-driven health services in project areas by pregnant/parenting women and infants.**
>
> **Increase community and provider understanding of the SCHIP and its eligibility requirement, provider location, service reimbursement and relevant issues. SCHIP outreach, enrollment, consumer advocacy and quality monitoring functions at all Healthy Start sites.**
>
> **Ensure 90% of the infants of Healthy Start clients receive age appropriate immunizations.**

Data Issues:

Data for the performance goals will come from the Healthy Start Replication Phase Data Reporting Requirements, developed in collaboration with the Healthy Start grantees to be useful for both Federal and grantee purposes. The requirements were pilot-tested and are being submitted for OMB clearance.

Data Limitations and Planned Improvements:

As noted earlier, community-based grantees do not always start with the capacity to provide all the data that might be desired. The Healthy Start program has worked with grantees to help them develop data systems appropriate to their functions and objectives, and have advised them on alternative sources and strategies for data. This assistance and advice will continue.

2.12.b Traumatic Brain Injury Program

Performance Goals	Targets	Actual Performance	Refer-ence
IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Promote Education and Training of the Public Health and Health Care Workforce** 1. Increase the number of States with educational and training materials, and programs for consumers, families and professionals.	FY 01: 15 FY 00: 11 FY 99: 7	FY 01: FY 00: FY 99: 8 FY 98: 0 (7 in process)	B198
C. Promote Systems and Infrastructure Development 1. Increase the number of States with TBI core capacity that includes: a State Action Plan, Statewide Needs Assessment, designated State agency staff, and State Advisory Board.	FY 01: 35 FY 00: 30 FY 99: 25	FY 01: FY 00: FY 99: 25 FY 98: 13	B198
Total Funding: **Traumatic Brain Injury Program** ($ in 000's)	[FY 2001: $5,000] [FY 2000: $5,000] [FY 1999: $4,998] [FY 1998: $2,991] (Funding for the TBI program is shown in the Maternal and Child Health Block Grant line).	B x: page # budget HP: Healthy People goal	

2.12.b.1 Program Description, Context and Summary of Performance

Congress has authorized HRSA to improve services for traumatic brain injury (TBI) survivors through a program of demonstration grants to States to improve health and other services for the assessment and treatment of TBI. The TBI Demonstration Grant Program is designed to emphasize activities by States that implement State-wide systems that ensure access to comprehensive and coordinated TBI

services. A comprehensive system of care is needed to improve all aspects of services available for individuals with TBI and their families including: pre-hospital care, emergency department care, hospital care, rehabilitation, transitional services, education and employment, and long-term community support.

According to a recent General Accounting Office (GAO) study of services, adults with TBI often have permanent disability that requires long-term supportive services to remain in the community. In an analysis of nine States, the gap between the number of individuals with TBI receiving long-term services and the estimated number of disabled adults with TBI remains wide.

The HRSA TBI program is part of a three HHS agency effort with CDC and NIH. Collaboration occurs with the Department of Education/Office of Special Education and Rehabilitation services, the Veteran's Administration, and the Administration on Developmental Disabilities.

2.12.b.2 Goal-by-Goal Presentation of Performance

Goal IV.B.1: Increase the number of States with educational and training materials, and programs for consumers, families and professionals.

Context:
Increasing the number of States with educational and training materials, and programs for consumers, families and professionals will increase the knowledge base and improve care delivery for TBI patients.
Indicator: Number of States with educational and training materials and programs.

Performance: FY 99 Actual Performance was higher than the FY 99 Target.

Goal IV.C.1: Increase the number of States with TBI core capacity that includes: a State Action Plan, Statewide Needs Assessment, designated State agency staff, and State Advisory Board.

Context:
The identified components of TBI core capacity are critical to assuring increased quality of care for TBI patients.
Indicators:

- Number of States with a State Action Plan (Baseline 13).
- Number of States with a Statewide Needs Assessment (Baseline 13).
- Number of States with a designated State agency staff (Baseline 13).
  Number of States with a State Advisory Board (Baseline 25).

Performance:
FY 99 Actual Performance met the FY 99 Target.

The following two goals have been discontinued. The difficulty in measuring them exceeds their value as indicators.

Goal IV.C.2: Increase the number of States that coordinate public (RSA, Special Education, Medicaid, Title V, etc.) and private (insurance, etc.) resources to assist individuals and families in developing long-term financial support to secure community and/or health services.

Goal IV.C.3: Increase the number of States that track program implementation of services for people with TBI to narrow the gap between those disabled by TBI who receive services and those disabled by TBI not receiving services.

Data Issues:
Data to be collected from an annual survey of grantees, being developed and prepared for OMB clearance.

2.13 Program Title: Universal Newborn Hearing Screening

Performance Goals	Targets	Actual Performance	Refer-ence
III. ASSURE QUALITY OF CARE **A. Promote Appropriateness of Care** 1. Increase the percentage of newborns who have been screened for hearing impairment before hospital discharge. (New)	FY 01: 40%	FY 01: FY 00: FY 99: (June, 00) FY 98: 20%	B203
Total Funding: Universal Newborn Hearing Screening ($ in 000's)	FY 2001: $3,375 FY 2000: $3,375 FY 1999: n/a FY 1998: n/a	B x: page # budget HP: Healthy People chapter	

2.13.1 Program Description, Context and Summary of Performance

HRSA proposed a new program for FY 2000 to promote newborn hearing screening as a standard of care. This initiative will address critical gaps by supporting grants to the States to: (1) develop and expand statewide universal newborn hearing screening programs, (2) link screening programs to intervention within the community service system, (3) monitor the impact of early detection and intervention on child, family, and systems, and (4) provide technical assistance.

At the current stage of development of the universal newborn hearing program in this country, 80 percent of infants are still not screened prior to hospital discharge. In those areas where universal newborn hearing screening is occurring, appropriate and timely diagnosis and intervention continues to be a major challenge. Attrition rates as high as 60 percent between initial referral and diagnostic confirmation are still not unusual, and linkages between screening programs and early intervention programs are yet not well-established.

This effort is one component of an on-going multiple agency partnership with the CDC, NIH, and the Department of Education.

2.13.2 Goal-by-Goal Presentation of Performance

Goal III.A.1: Increase the percentage of newborns who have been screened for hearing impairment before hospital discharge. (New Performance Goal)

Context:
This Goal replaces the four developmental goals (see below) proposed last year, as a measure more accurately reflecting the activities proposed and the health outcomes being addressed, and one for which data are available.

Increasing the percentage of newborns who have been screened for hearing impairment before hospital discharge is the first step toward improving the early diagnosis and treatment of infants with hearing impairment.

Indicator: The percentage of newborns who have been screened for hearing impairment before hospital discharge.

The following four developmental goals have been replaced:
* 90 percent of eligible infants will be referred to and receive early intervention services by 6 months of age. (Developmental)
* 90 percent of infants identified through screening programs will have an identified medical home. (Developmental)
* The average age of diagnosis will be reduced to 3 months, with amplification by 6 months. (Developmental)
* 50 states will have established statewide universal newborn hearing screening programs. (Developmental)

Data Issues:

Data Collection and Validation:
Data for the new performance goal is available from the National Center for Hearing Assessment and Management (NCHAM). It is also reported annually by the States in the Title V State Block Grant Annual Report and Application, as Performance Measure #10.

Data Limitations and Planned Improvements:
The data obtained from NCHAM are at least as good as the data reported by the States annually.

2.14 Emergency Medical Services for Children

Performance Goals	Targets	Actual Performance	Refer-ence
IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **C. Promote Systems and Infrastructure Development** 1. Increase the number of States that have implemented Statewide pediatric protocols for medical direction. (Modified wording to focus on Statewide implementation.)	FY 01: 15 (Statewide) FY 00: 20 (Statewide/ partial) FY 99: 18 (Statewide/ partial)	FY 01: FY 00: FY 99: 25 (10 Statewide, 15 partial) FY 98: 16 (6 Statewide, 16 partial)	B205
2. Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) ambulances.	FY 01: 23 FY 00: 10 FY 99: 7	FY 01: FY 00: FY 99: 18 FY 98: 5	B205
Total Funding: Emergency Medical Services for Children ($ in 000's)	FY 2001: $15,000 FY 2000: $17,000 FY 1999: $14,995 FY 1998: $12,941	B x: page # budget HP: Healthy People goal	

2.14.1 Program Description, Context and Summary of Performance

The EMSC program is designed to ensure that all children and adolescents, no matter where they live or where they travel, receive appropriate care in a health emergency. It seeks to improve all aspects of children's acute emergency medical care, including pre-hospital care, emergency department care, hospital care, and rehabilitation, and it seeks to prevent such emergencies from occurring. The EMSC program is the only Federal program that focuses on improving the quality of children's emergency care.

The system for pediatric emergency care has many deficiencies. Fewer than half (46%) of hospitals with emergency departments have the necessary equipment for stabilization of ill and injured children. In 1998, only 5 States required that Advanced Life Support vehicles carry all equipment needed to stabilize a child. Only 11 States have guidelines for acute care facility identification for pediatrics to ensure that children get to the right hospital in a timely manner. Only 40% of U.S. hospitals with

emergency departments have written transfer agreements with a higher level facility to ensure that children receive timely and appropriate hospital care when they need it. Finally, systems are not in place to assess and evaluate pediatric emergency care: only 9 States have the capacity to produce reports on pediatric EMS using Statewide EMS data.

The EMSC program has been a joint effort of HRSA and DOT's National Highway Traffic Safety Administration since its inception in 1985 and has been cited by the Institute of Medicine as an excellent example of government collaboration. The program collaborates with CDC's National Center for Injury Prevention and Control, SAMHSA's Emergency Services and Disaster Relief Branch, and FEMA's Disaster Response Team; and has a close relationship with 14 national organizations representing EMS professionals and other interested groups.

2.14.2 Goal-by-Goal Presentation of Performance

Goal IV.C.1 Increase the number of States that have implemented Statewide pediatric protocols for medical direction. The wording of this performance goal has been changed to emphasize the implementation of Statewide protocols.
Previous wording: Increase the number of States that have pediatric protocols for both online and offline medical direction.

Context:
Having Statewide pediatric protocols for medical direction within a State will increase the standard of care for pediatric emergency patients.
Indicator: Number of States with Statewide pediatric protocol for medical direction.

Performance:
FY 99 Actual Performance of 25 was significantly higher then the FY 99 Target of 18.

Goal IV.C.2: Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) ambulances.

Context:
Requiring all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) ambulances will increase the quality and appropriateness of care for pediatric emergency patients.
Indicator: Number of States that require all pediatric equipment on ALS ambulances.

Performance:
FY 99 Actual Performance of 18 States was significantly higher that the FY 99 Target of 7.

Data Issues:

Many of the changes to be accomplished by this program will take some time to accomplish, annual measurement would not show much effect. This is especially true for outcomes, the impact on which will be assessed over five-year periods. On the other hand, the performance measures shown here can and will be assessed annually. An annual reporting form that will be required of grantees is now in preparation for OMB clearance. This form should be available for use by mid-2000.

2.15 Poison Control Centers

Performance Goals	Targets	Actual Performance	Refer-ence
III. ASSURE QUALITY OF CARE **A. Promote Appropriateness of Care** 1. Increase the number of uniform and evidence-based guidelines available for approval by the American Association of Poison Control Centers, to be used in Poison Control Centers.	FY 01: 5	FY 01: FY 00: FY 99: 0	B206
Total Funding: Poison Control Centers ($ in 000's)	FY 2001: $1,500 FY 2000: $3,000 FY 1999: n/a FY 1998: n/a	B x: page # budget HP: Healthy People goal	

2.15.1 Program Description, Context and Summary of Performance

A new program has been initiated in FY 2000 to address problems related to poison control services. FY 2000 funds will be used by HRSA primarily to support the development and assessment of uniform patient management guidelines. This will provide consistent, evidence-based protocols nationally and will result in improved quality of service. This builds on funding allocated in FY 99 by CDC, with support from HRSA, to develop a national toll-free telephone number for poison control and initiate a public education campaign to advertise this number. This will go far to improving access to poison control services nationwide. All activities in support of Poison Control Centers are part of a joint HRSA/CDC initiative. With the exception of the toll-free number, budget requests to support this effort will come through HRSA.

The activities are based on recommendations contained in the Final Report of the Poison Control Center Advisory Group, an ad hoc group called together by HRSA/CDC in response to a request

from HHS to develop a plan to address the poison control center crisis. Their recommendations which are essential to stabilize and improve the system and assure universal access to poison control services form the basis for these proposed activities.

2.15.2 Goal-by-Goal Presentation of Performance

Goal III.A.1: Increase the number of uniform and evidence-based guidelines available for approval by the American Association of Poison Control Centers, to be used in Poison Control Centers.

Context:
Having evidenced-based guidelines available for use at the Poison Control Centers will improve the standard of care for acute poisoning-related incidents, thereby improving the quality of care.

Data Issues:
Most data will be collected from annual applications and reports from grantees.

2.16 Program Title: Abstinence Education Program - Title V

Performance Goals	Targets	Actual Performance	Refer-ence
I. ELIMINATE BARRIERS TO CARE **C. Focus on Target Population** 1. Achieve State-set targets for reducing the proportion of adolescents who have engaged in sexual intercourse.	FY 01 (06/00)	FY 01: FY 00: FY 99: (01/01) FY 98: (06/00)	B208
2. Achieve State-set targets for reducing the incidence of youths 15-19 years old who have contracted selected sexually transmitted diseases in 50 percent of the participating States.	FY 01: (06/00)	FY 01: FY 00: FY 99: (01/01) FY 98: (06/00)	B208
3. Achieve State-set targets for reducing the rate of births to teenagers aged 15-17 in 50 percent of the participating States.	FY 01: (06/00)	FY 01: FY 00: FY 99: (01/01) FY 98: (06/00)	B208
Total Funding: Abstinence Education Program ($ in 000's)	FY 2001: $50,000 FY 2000: $50,000 FY 1999: $50,000 FY 1998: $50,000	B x: page # budget HP: Healthy People goal	

2.21.1 Program Description, Context and Summary of Performance

This program provides formula grants to the States for the purpose of providing abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out of wedlock.

The trends over the past several decades show that increasing proportions of teens have had sexual intercourse. Sexual experience, and particularly the age at first intercourse, represent critical indicators

of the risk of pregnancy and sexually transmitted diseases. After years of increases, the teen birth rate declined by 16 percent from 1991 to 1997, with all States reporting a decline in the birth rate of teens 15-19 years old between 1991 and 1997, according to the Centers for Disease Control and Prevention. The proportion of students who had sexual intercourse also fell 11 percent during the 1990's. Despite these recent declines, teen pregnancy and out-of-wedlock sexual activity remain significant problems in communities across the country.

The Abstinence Education Grant Program is a key component of the National Strategy to Prevent Teen Pregnancy announced by Secretary Shalala in January 1997. This Strategy presented a comprehensive plan to prevent teen pregnancies in the United States by strengthening, integrating, and supporting teen pregnancy prevention and other youth-related activities in communities across the country. The Department of Health and Human Services is committed to involving a wide range of partners in its teen pregnancy prevention efforts, including national, State, and local organizations; schools; health and social service organizations; business; religious institutions; tribes and tribal organizations; federal, State and local governments; parents and other family members; and teens themselves. In communities around the country, there is increasing recognition that helping teens to avoid pregnancy requires multiple programs and strategies. Since the causes of teen pregnancy are complicated and overlapping, solutions must have many parts and approaches.

Established by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and first funded in fiscal year (FY)1998, the Abstinence Education Grant Program is still in its early stages. The annual applications for the program, due in July of each calendar year for the next FY, will report data for the preceding FY. Data for the first year of operation, FY 1998, will be reported in the applications received in July 1999, and should be processed and available by June 2000.
The Department, through the Office of the Assistant Secretary for Planning and Evaluation (ASPE), is responsible for conducting an evaluation of the State Abstinence-only Education Grants. There were no provisions made in the original legislation for a Federal evaluation of the Abstinence Education Grant Program. The Balanced Budget Act of 1997 set aside funding for Federally-sponsored evaluations of Section 510 abstinence-only educations programs. In August 1998, Mathematica Policy Research was awarded the contract of the Evaluation of Abstinence-only Education Programs. This project is a three-year multi-site effort to improve knowledge about programs aimed at preventing teen sexual activity and its negative consequences. The evaluation will focus on nine sites involving random assignment experiments and, possibly, five sites involving comprehensive community-wide initiatives. Data collection was scheduled to begin in the fall of 1999.

The proportion of States who met their individual objectives for FY 1998 for the three specified performance measures has not presently been compiled. It is anticipated that the data for States who reported an FY 1998 performance indicator for the specified measures in their FY 1998 annual report will be compiled by June 2000. "The national targets for FY 2001 will be set when the baselines for FY 1998 become available in June 2000."

2.21.2 Goal-by-Goal Presentation of Performance

Goal I.C.1: Achieve State-set targets for reducing the proportion of adolescents who have engaged in sexual intercourse in 50 percent of the participating States.

Nationwide, approximately 53% of all high school students have had sexual intercourse during their lifetime. There are some indications that early sexual intercourse by adolescents can have negative effects on social and psychological development. Abstinence-only education programs are a way to educate young people and create an environment within communities that support teen decisions to postpone sexual activity.

Baseline: June 2000
Performance FY 1999: January 2001
Target FY 2001: June 2000

Indicator: The percentage of participating States that achieve State-set targets.

Goal I.C.2: Achieve State-set rates for reducing the incidence of youths 15-19 years old who have contracted selected sexually transmitted diseases (STDs) in 50 percent of the participating States.

STDs are preventable diseases and the availability and quality of sexually transmitted disease services are important factors in preventing the spread of disease and complications. The majority of STDs occur in people aged 15-29 years. By age 21, approximately 1 of every 5 young people has required treatment for an STD. Primary and secondary prevention approaches are effective ways to reduce STDs. Abstinence-only education programs are one way to educate young people regarding the relationship of sexual activity and STDs.

Baseline: June 2000
Performance FY 1999: January 2001
Target FY 2001: June 2000

Indicator: The percentage of participating States that achieve State-set targets.

Goal I.C.3: Achieve State-set targets for reducing the rate of births to teenagers aged 15-17 in 50 percent of the participating States.

Teen pregnancy is a major threat to healthy and productive lives. Teen parenting is associated with the lack of high school completion and initiating a cycle of poverty for mothers.

Baseline: June 2000

Performance FY 1999: January 2001
Target FY 2001: June 2000

Indicator: The percentage of participating States that achieve State-set targets.

Data Collection and Validation:

Data for all performance measures will be reported in the annual formula grant applications. These applications, due in July of each calendar year for the next fiscal year (FY), report data for the preceding FY. Data for the first year of operation, FY 1998, as reported in July 1999, will be processed and available by June 2000.

Data Limitations and Planned Improvements:

The States do not all have good data for some measures related to teenage sexual behaviors, so there may be some difficulty in obtaining high quality data in the early stages of this program. Every effort will be made to work with the States to improve the quality of their data as quickly as possible. In addition, not all States were able to report annual performance indicators for FY 1998 in their FY 1998 annual reports. It is anticipated that an increased number of States will be able to report FY 1998 annual performance indicators in their FY 1999 annual reports.